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# The strategic geographies of global health partnerships

## Introduction

In 2006, 57 countries were classified as having a serious health workforce shortage by virtue of failing to meet the World Health Organisation's (WHO) 'critical threshold' of the 23 health workers per 10,000 population needed to meet the health-related Millennium Development Goals (MDGs). Of these "Human Resources for Health (HRH) crisis countries", 63% were in the WHO Africa Region (WHO, 2006a). Thus while African countries bore 24% of the global burden of disease in 2006, they had only 3% of the world's health workforce (WHO, 2006b). Given this, it is unsurprising that the "health workforce crisis" (*ibid*) came to be identified as one of the major factors undermining the Health Systems Strengthening (HSS) needed to achieve the health-related MDGs such as reducing child mortality, combatting AIDS, malaria and other diseases and providing access to safe, affordable medicine (Hafner and Shiffman, 2013). This urgency was further reinforced by a 2004 report by the Rockefeller Foundation's Joint Learning Initiative (Chen et al., 2004), the 2006 and 2008 *World Health Reports* and the World Health Assembly's (WHA) target of reducing the number of "crisis countries" by 25% by 2015. Yet, by 2013 and despite the energy mobilised by the 2008 Global Forum on Human Resources for Health in Kampala, a Global Health Workforce Alliance report noted that the number of "HRH crisis" countries had actually grown to 88 as population growth outpaced health worker recruitment (2013). As such and as Panter-Brick *et al* note, it is clear that HSS 'provides a crucial opportunity for global health action' (2014, 4), even if its empirical substance and theoretical possibilities represent a persistent absence within the social scientific study of global health. This omission not only marks a limit of recent geographical engagements with global health (Brown and Moon, 2012; Herrick, 2014, 2016; Herrick and Reubi, 2017; Hinchliffe, 2015; Reubi et al., 2016; Taylor, 2016), but perhaps more importantly a missed opportunity to use GHPs as a vehicle through which to enhance the current conceptual language by which we think through the increasing entwinement of the global health and development domains (Murray, 2015; Rieder, 2016).

While HSS has – and continues to be – a widely-agreed prerequisite for the achievement of the health MDGs and now the SDGs, there has experienced consistent under-investment by the major global health funders and policy community (Hafner and Shiffman, 2013; Storeng, 2014). Instead funders have largely preferred to support 'siloed' vertical interventions to produce narrow MDG-driven results with the hope that, in so doing, 'the [health] system will be strengthened more generally' (Travis et al., 2004, 900). Yet 'if health systems are lacking capabilities in key areas such as the health workforce, drug supply, health financing, and information systems, they may not be able to respond adequately to such opportunities... already weak systems may be further compromised by over-concentrating

resources in specific programmes, leaving many other areas further under-resourced' (*ibid*). Thus, competent health systems with an adequate workforce are essential to realise and sustain the benefits of what has been retrospectively termed the "golden era" of global health funding and investment (Kickbusch and Szabo, 2014; Morrison, 2012). This issue was picked up by Margaret Chan, WHO Director-General, in her assertion that single-disease initiatives and HSS 'do not represent a set of either-or options. It is the opposite. They can and should be mutually reinforcing. We need both' (Chan, 2009). It is thus notable that in contrast to the disease-specific MDGs; the SDGs directly note the centrality of HSS to achieving Universal Health Coverage (UHC) as well as avoiding the multiple, adverse consequences of "catastrophic" health expenses (Pablos-Mendez et al., 2016). As attention turns to the question of how best to deliver HSS (see Esser, 2009), I want to reflect on one increasingly important – but under-analysed - mechanism: The global health partnerships (GHPs) supported through the UK's Overseas Development Assistance (ODA) strategies. GHPs conjoin government, NGOs, civil society, universities, global health funders and the private sector. They aim to support national health strategies in LMICs, skills development provide technical assistance and deliver health worker training. Importantly, they also serve an essential geopolitical function in using health as a means by which to increase the UK's international influence, "soft power" as well as strengthening core skills and competencies in its own National Health Service (NHS).

In this paper, I will thus explore how these GHPs function as specific sites where global health and development meet and thus where particular geographies matter. These geographies are not representative of the spatial distribution of health "need" but rather of geopolitical and ODA exigencies. As such, here I will argue that critically reflecting on *where* GHPs are located is as important as dealing with the recent wave of calls to evaluate their efficacy (Lasker, 2016). Doing so will also mean pausing to consider the question of "who, then, global health is really for" (Horton, 2014). This exploration will proceed in three parts. First, I will set out the UK policy context in which GHPs for HSS have flourished. This is an important empirical contribution to the global health field in a context where the UK government's role has been remarkably under-explored by social scientists in this deeply US-centric field, despite the scale of UK ODA allocated to the sector. Second, I will explore how GHPs clearly demonstrate the increasingly blurred lines between global health and development and, therefore, the need to refuel current critical engagements with global health with a greater cognisance of the increasing interconnections between the two. In the third part, I will reflect on how the geographies of GHPs are far from benign and, also, far removed from the health needs they purport to address. Instead the geographies of GHPs are a reflection of a certain style of strategic geopolitical thinking angled towards delivering efficiency in ODA outcomes. As such, GHPs are not only potent

geopolitical entities, but they also advance a particularly strategic uptake and deployment of geography itself. These geographies then become self-reinforcing as those countries prioritised as having the greatest “strategic advantage” by the UK’s Department of International Development (DFID) then become the sites where GHPs are most likely to locate. In exploring this, I hope to open up a new arena of conceptual and empirical investigation not only to geographical engagements with global health, but also to the nexus where global health and development encounter each other.

### **The UK, global health partnerships and development**

In 2006, Lord Crisp – past Chief Executive of the NHS - was commissioned by then-Prime Minister Tony Blair to write *Global Health Partnerships: The UK contribution to health in developing countries*. Emerging from discussions and promises made at the 2004 Commission for Africa, the 2005 G8 ‘Make Poverty History’ Summit at Gleneagles and further cemented by the 2007 publication of the Chief Medical Officer’s *Health is Global* strategy (Donaldson and Banatvala, 2007); the *Crisp Report* arguably set the stage for new era in global health governance in the UK. The G8 Summit highlighted that the global shortage of healthcare workers (especially in Africa) would need to be addressed to be able to realise the promise of basic healthcare for all (Smith and Henderson-Andrade, 2006). This issue was then taken up in the 2006 WHA Resolution (WHA59.23) on rapid scaling up of health workforce production, which was further underpinned by the rationale that the chronic shortage of health workers in LMICs was eroding the efficacy of the new global health financing mechanisms (i.e. the Global Fund, the GAVI Vaccine Alliance etc.). As a result, ‘in many countries, there is simply insufficient human capacity to absorb, deploy and use efficiently the financing offered by global health initiatives’ (WHO, 2006c). Furthermore, and as a series of recent anthropological accounts have shown, many of these initiatives create complex, parallel NGO/state/private healthcare economies (Crane, 2013; Marchal et al., 2009; Pfeiffer, 2013; Rieder, 2016; Taylor and Harper, 2014), often further perpetuating healthcare worker and skills shortages and resource allocation imbalances (Groenhout, 2012; Raghuram, 2009). For this reason, WHA Resolution 59.23 calls on all countries to implement sustained action to address the health worker crisis (WHO., 2006b, 5) with suggested strategies ranging from international investment in the domestic health workforce training pipeline, improving health education infrastructure, reducing medical school drop-out rates, enhancing the career development of Community Health Workers and producing a skills mix that better reflects biomedical and public health challenges. The WHO notes that this will require increased donor funding as well as a ‘paradigm shift’ away from disease-specific projects and interventions to investment in a more sustainable and holistic model able to ‘properly address the technical and political challenges of health workforce

development’ (WHO, 2006b, 9). Amid this, GHPs have emerged as an important potential mechanism or ‘lever of change’ (Crisp, 2007) through which to effect and enact this paradigm shift.

The Crisp Report emerged from a belief that ‘the UK and its professionals also have a great deal to learn and gain from people in developing countries, particularly in the context of international health challenges’ (Blair in Crisp, 2007, iii). The report thus helped set the stage for a rapid proliferation of GHPs touted as the most opportune and cost-effective way to enact country-led development, addressing the global healthcare staffing crisis (see Bach, 2015; Kumar, 2007; List, 2009; Mackey and Liang, 2012) and servicing the proliferation of global health programmes and overseas medical electives at UK universities (Crane, 2011; Herrick and Reades, 2016). This not only gave the NHS a significant global health role – something later reinforced through the government’s 2008 *Health is Global* strategy - but also echoed the broader policy momentum behind supporting health as a determinant and driver of economic development (Sachs, 2002; World Bank, 2007; Mitchell and Sparke, 2015; see also Mawdsley, 2015). Since the publication of the Crisp Report, the UK’s commitment to GHPs has only grown. The Tropical Health Education Trust (THET) has managed DFID’s health partnership scheme since 2006 and, to date, has supported 85 partnerships in 26 countries in Africa and Asia, which have involved 1,000 NHS volunteers reaching 25,000 overseas health workers (THET, 2016)<sup>1</sup>. The NHS commitment to partnerships and international volunteering is even formalised in its Constitution, with the ‘business case’ predicated on the belief that many global health challenges (e.g. tuberculosis) also affect the UK and may be better tackled through skills and insight gained by NHS staff while on placement in the global south. It is also bolstered by a belief that NHS staff undertaking international placements might forge the skills and experience needed to tackle the particular health needs of British citizens of overseas origin. NHS support for overseas placements for its staff within GHPs was also set out in the House of Commons International Development Committee’s recent report *Strengthening Health Systems in Developing Countries* (2014) and further facilitated through the NHS’ own human resources and career progression protocols. It is also notable that GHPs have become a significant component of international volunteering more broadly, with 20% of Voluntary Service Overseas (VSO) expenditure now going on health (All-Party Parliamentary Group on Global Health, 2015).

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<sup>1</sup> THET partnerships fall into three categories: Multi-country partnerships; paired institutional partnerships and long-term volunteering. Examples include the University of Manchester’s ‘Lupina Africa Midwives Research Network’ with midwifery schools in Kenya, Malawi, Zambia, Uganda, Zimbabwe and Tanzania (multi-country) and King’s College London Sierra Leone Partnership’s ‘Education Strengthening Project’ with Freetown’s Connaught Hospital and the College of Medicine and Allied Health Sciences (paired institutional partnership) and VSO’s maternal health in Malawi’s long-term volunteering arrangements with the Kamuzu College of Nursing.

Such a view of GHPs demonstrates the complete entwinement of health and ODA in which global health shifts from being a 'discontinuous' crisis-driven foreign policy matter, to becoming a 'broader policy instrument' that better reflects 'the longitudinal importance of health as a human security concern' (Horton, 2006; Lakoff, 2010). In the UK context, this shift from health as a 'national security' to 'human security concern' is mainly operationalised through the remit, work and funding streams of DFID which now channels 25% of its health funds into health workforce capacity strengthening across its 27 focus countries. Indeed, as DFID's recent report on global health sets out, the rationale for this approach is that 'better health is an end in itself and a basic human right, to which many poor people do not have access... [it] also contributes in several ways to higher productivity and hence economic growth' (2013, 3). The belief in the developmental value of GHPs is also, unsurprisingly, supported by THET who argue in their *Strategic Plan 2016-2021* that 'we are entering an era in which traditional approaches to overseas aid are giving way to new forms of development, involving new sources of finance and new partnerships... [this approach] enables countries to work more collaboratively and at scale, because it is grounded in the concept of mutual benefit, of co-development and co-learning' (2016, 7). These ideas of co-development, co-learning and what has been termed 'reverse innovation' (Busse et al., 2014; Syed et al., 2013) whereby knowledge, ideas and skills flow from south to north are central to the philosophy of GHPs. Yet, while GHPs have been subject to critique *on the ground*, for how their intentions unfold relative to their actual effects and for how they are experienced *in situ* (Brown, 2015; Crane, 2013; Wendland, 2010) as well as for doing little more than 'putting old wine in new bottles' (Marchal et al., 2009, 4); there has been less overt engagement with their (geo)politics and, moreover, the significance of their geographies. This paper represents a first move to address this gap.

### **The geopolitics of global health partnerships**

Simon Reid-Henry has recently argued that 'mainstream global health today seeks to fill in the potholes of global ill-health; it does not seek to reconstruct the road itself' (2016, 721). Among the wide range of critiques of global health, this is a common refrain: that the field is merely a palliative focussed on cure and side-steps (thereby often worsening) the fundamental social, political and economic determinants of health as well as the inequalities that sustain them. While I agree with his assertion that, when viewed through the spectre of the Gates Foundation or GAVI; global health 'quite explicitly seeks to avoid challenging the systemic aspects of global health problems' (2016, 721), I do not concur that 'modern conceptions of global health rarely focus on fundamental public health services' (*Ibid*, see also Gostin, 2015). There is little doubt that global health at its most spectacular and popular – the kind that motivates the TEDx talks and celebrity interventions that Reid-Henry notes

– is rarely about *public health*. Instead, global health is far more often than not a tale of metrics-driven scientific discovery, therapeutic advances and innovation (Adams, 2013, 2016b; Moran, 2016). This is a problematic characterisation, not least because it means that the critical global health field, while engaging with the topic of partnerships, has tended to ignore the extent to which *national* global health and development policies are being operationalised through them (McGoey, 2014; Sebert Kuhlmann and Iannotti, 2014). This is an arena where geopolitical engagements with global health (c.f. Barker, 2012; Brown et al., 2012; Ingram, 2005, 2009; Weir and Mykhalovskiy, 2007) might productively turn their attention to a far wider range of actors than has yet been the case. This might help address lacunas such as, for example, the paucity of critical engagement with the NHS as a significant and powerful global health actor. To do so, would in turn draw attention to alternative types of geopolitics to those which have animated past accounts (see Lakoff, 2010). GHPs are inherently geopolitical in the sense that their HSS remit cuts across those very same determinants of health are so often drawn out as the grand omission of most global health activity (McCoy and Singh, 2014). Indeed, as a ‘modality of intervention’ (Harper and Parker, 2014, 199), GHPs are inherently and overtly political as an instrumental route to help the UK ‘strengthen its influence and soft power as the best networked country in the world’ (All-Party Parliamentary Group on Global Health, 2015, 6). Far from an altruistic gesture, GHPs offer a means to the genesis of soft power which occurs ‘when one country gets other countries to want what it wants... [through] intangible power resources such as culture, ideology, and institutions’ (Nye, 1990, 166). Health is a particularly efficient route to soft power as it has a veneer of neutrality (Feldbaum and Michaud, 2010), even if this is so rarely the case in practice (Ingram, 2005).

In considerations of the geopolitics of global health; accounts have tended to focus on two particular “regimes” for ‘envisioning and intervening upon the field’ (Lakoff, 2010, 59) – security and humanitarianism. As Reid-Henry argues, however, ‘there are certainly more than just two regimes’ (2016, 714). And, as Lakoff (2014) himself suggests, these two regimes are more often than not elided, with GHPs a clear example where security and humanitarian need come together. Indeed and as historian Alison Bashford has argued, ‘while once disease prevention and geopolitics were simply related, more recently the former has become a vehicle for, and even an instrument of, the latter’ (2007, 2). Such an idea is important as the regime of ‘security’ has, as Bashford has argued, ‘spatial implications’ (2007, 1) in its tendency to be tied to the idea of safeguarding sovereign territory against increasingly borderless and global disease threats (Barker, 2015; Collier and Lakoff, 2015). While the justificatory case for GHPs is partly anchored in this worldview, they go beyond the idea of borders as ‘abstract lines on maps’ and instead become ‘a set of practices on the ground’ (Bashford, 2014, 7).

Anthropological accounts of partnerships have worked with this idea in their consideration of partnership working *in situ* (Wendland, 2010). Some accounts have also grappled with more dynamic notions of borders with partnerships considered as mechanisms linking people, places and ideas and often vastly uneven power relationships (Crane, 2013). Here I want to contribute to and add a new layer to this field by critically unpacking the processes and politics by which the geographical contours of UK GHP investment have been formed. Johanna Crane has argued that GHPs exhibit a renewed ‘scramble for Africa’ (Crane, 2011; 2013), an assertion that chimes with a recent *Lancet* debate on the extent to which global health might be considered a ‘neo-colonial’ endeavour, especially when considered a ‘polite way to decorate [the] repackaged colonial ambitions of development policy’ (Horton, 2013). In this vein then, the entwined geographies of GHPs and ODA also highlight the degree to which ‘global health is not yet global’ (Byass, 2013, 2).

### **Strategic geographies**

With 60% of DFID’s bilateral spend in Africa, almost 40% in (mostly South) Asia, and the remaining 1% spread across the rest of the world (Americas, Pacific and Europe), there is a clear trade-off between the achievement of results through targeting aid and programmes to those countries which will deliver the best return on investment and those countries and regions of greatest need. At present, 50% of UK multilateral funding currently goes to Africa and 19% to Asia, with the top five recipient countries Pakistan, Nigeria, Afghanistan, Tanzania and Ethiopia. These have vastly different health need profiles and levels of development, but nevertheless represent geopolitically significant countries for the UK’s deployment of soft power. As such, while the UK is influential in global health, the geographic reach of this influence is limited to the ‘countries where the UK has a comparative advantage due to its historical connections, and therefore represent[s] a strategic approach’ (All-Party Parliamentary Group on Global Health, 2015, 80). Indeed, only 11% of funding goes to countries with which the UK has no historical ties (Fitchett et al., 2014). This is a strategy that sits uneasily with the idea of global health as a shared moral project with the delivery of socially just health outcomes at its core (Wernli et al., 2016). Indeed, if the map of global health was needs-based, it would look remarkably different. For example, between 1997 and 2010 the five countries with the highest infectious disease rates were Uganda, Zimbabwe, South Africa, Malawi and Tanzania. However, the geography of ODA recipient countries shows that spending does not easily follow the kind of ‘neo-colonial’ ties that some have suggested (Horton, 2013) and instead reflects a more complex vision of a country’s ‘comparative advantage’. As such, this raises important questions about the extent to which global health activity is divorced from the very global burden of disease that it claims to address (Kenworthy, 2014). In this case, the disease burden alone fails to act as the kind of ‘allocative driver’ (Esser and Bench, 2011,



1276) that might be expected given global health's bold proclamations and endless quantifications of "lives saved" (Adams, 2016a). The UK's global health activity exhibits a remarkably restricted geography, which while ostensibly "strategic", also leaves it vulnerable to competition from the US and emergent global health players such as South Korea.

These restrictive geographies then beg the question, recently asked by the *Lancet's* editor Richard Horton (2014), of 'who, exactly, is global health for?' Thus, when thinking through the geographies of these partnerships, it is worth considering their inextricable entwinement with the changing landscape of DFID's aid priorities and, therefore, the landscape of global health funding. In 2010, the UK government commissioned a bilateral aid review with the express aim of reducing the number of DFID's target countries from 43 in 2008/9 to 27 by 2016 in order to ensure that its objectives might be met in the most cost-effective manner possible and with the 'greatest impact' (see figure 1) (DFID, 2011a). Under the Coalition Government, the strategy was therefore 'to refocus UK bilateral aid expenditure in fewer countries so that we can target our support where it will make the biggest difference and where the need is greatest (DFID, 2011b, 2). The review was also intended to ensure that DFID could meet the increased prioritisation of 'fragile and conflict-afflicted states' set out in the 2010 *Strategic Defence and Security Review* (HM Government, 2010). However, as a report on the review by the Africa All-Party Parliamentary Group contends, however, it was unclear from where the figure of 27 countries was derived. The authors speculated that it might have been the number arrived at after the exclusion of countries where the UK was thought to have 'limited comparative advantage' due to insufficient in-country presence (e.g. Niger) and those countries that have "graduated" from aid (e.g. Vietnam and Kosovo). The 'bottom-up' methodology chosen is worth dwelling on in some detail in order to contextualise just how the geographies of global health became so divorced from the distribution of mortality and morbidity, something that was not expanded upon in the All-Party Parliamentary Report on the *UK's Contribution to Health Globally*.

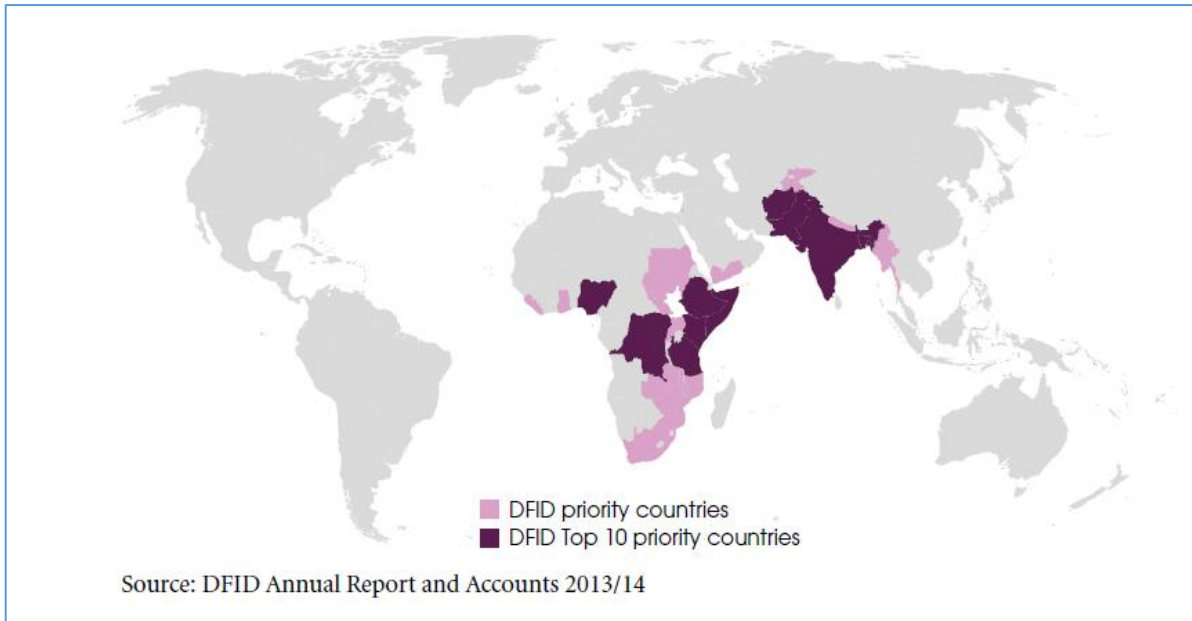


Figure 1 - DFID priority countries 2013/2014 (reprinted from APPG, 2015, 61)

The aid review drew upon a ‘Needs-Effectiveness Index’ (NEI) based on four measures: (1) the Human Development Index (HDI); (2) a fragility index; (3) the number of people living on less than \$2/ day and (4) the World Bank’s Country Policy and Institutional Assessment (CPIA) Score. In essence, indicators 1-3 represent measures of development “need” and 4 is a proxy measure for the likely “effectiveness” of aid given a country’s governance characteristics. There is a strong correlation between the fragility index and the CPIA score as fragile states are less likely to have good governance and vice versa. This means that HDI and population under \$2 a day have the greatest influence on the NEI. In turn, this means that the NEI ranks countries with the greatest “development need” higher than those that are “fragile” thereby putting it odds with the mandate of the *Strategic Defence Review*. Moreover, as the Index uses the *number* of people living in poverty, rather than the *proportion*, it gives greatest weight to those countries with the largest populations and over-values those countries which have more robust data and thus more accurate HDI scores. It also therefore undervalues those 23 countries that did not have an HDI score in 2010. The Africa All-Party Parliamentary Group report thus argues that the favouring of populous countries<sup>2</sup> was not necessarily justifiable as ‘there is little evidence to suggest that aid will be more effective in such countries and there is no convincing moral argument for doing more to aid poor people in large countries than poor people in smaller countries’ (2012, 6). The report’s authors expressed particular concern with the decision to close DFID’s bilateral programme in Burundi, pointing out that if the NEI had used the proportion of the population living in poverty then this ‘small, extremely poor, fragile country recovering from decades of civil war’ would

<sup>2</sup> The average DFID priority country population is 82 million. By contrast, the average population of those countries that were cut from the programme was 32 million.

not have been selected for programme closure. Instead, three countries – Nigeria, Ethiopia and the DRC – now account for 50% of DFID’s African funding.

As it stands, DFID’s 27 focus countries account for a third of the world’s population who, together, experience a significant burden of disease, disability, and premature death. Indeed, over 48% of the global burden of disease and more than 68% of the global burden of communicable diseases are found in DFID focus countries (All-Party Parliamentary Group on Global Health, 2015). This is obviously one direct measure of need, but it is also one that is not directly tied to the need for HSS and, therefore, does not represent a clear measure of GHP need. The problem is that there are few systematic ways of comparing the *need* for HSS at a global scale. The WHO’s Global Health Observatory offers up a variety of proxy measures, including out-of-pocket expenditure as a percentage of total health expenditure, the percentage of external resources for health (i.e. aid dependency) and government expenditure on health. It is worth noting, therefore, that with the exception of South Africa, DFID’s priority countries correspond clearly with those countries that had the lowest (i.e. less than \$100 per person per year) spending on health in 2014 (figure 2). However, with regards to UHC, the correlation is slightly more opaque. With the advent of the SDGs, the WHO has proposed a composite ‘health service coverage index’ (Leegwater et al., 2015) made up of 16 ‘tracer indicators’ including information on immunisation rates, service provision, infrastructure, human and financial resources (WHO, 2016). These measures are important because they raise significant questions about the location and nature of need for GHPs for HSS. When, for example, ‘impoverishing health expenditure’ is calculated; then a very different geography emerges where Egypt, Tajikistan, Georgia, Tunisia, Pakistan and Tanzania are the countries most afflicted. For ‘catastrophic’ health expenditure, the most afflicted countries become Tajikistan, Georgia, South Korea, Argentina and Egypt (*Ibid*). Yet, of these only Tajikistan is a DFID priority country. Given this, it is notable, but perhaps unsurprising, that the geography of THET’s GHPs (figure 3) and VSO health volunteer placements (figure 4) shows striking similarity with DFID’s priority countries, rather than reflecting the location of greatest need. This is doubtlessly because securing funding for GHPs is often dependent on being ODA compliant and is much more likely to build on existing in-country contacts, networks and ties and capitalise on existing institutional links than undertake the uphill task of developing new ones, even where need may be acute.

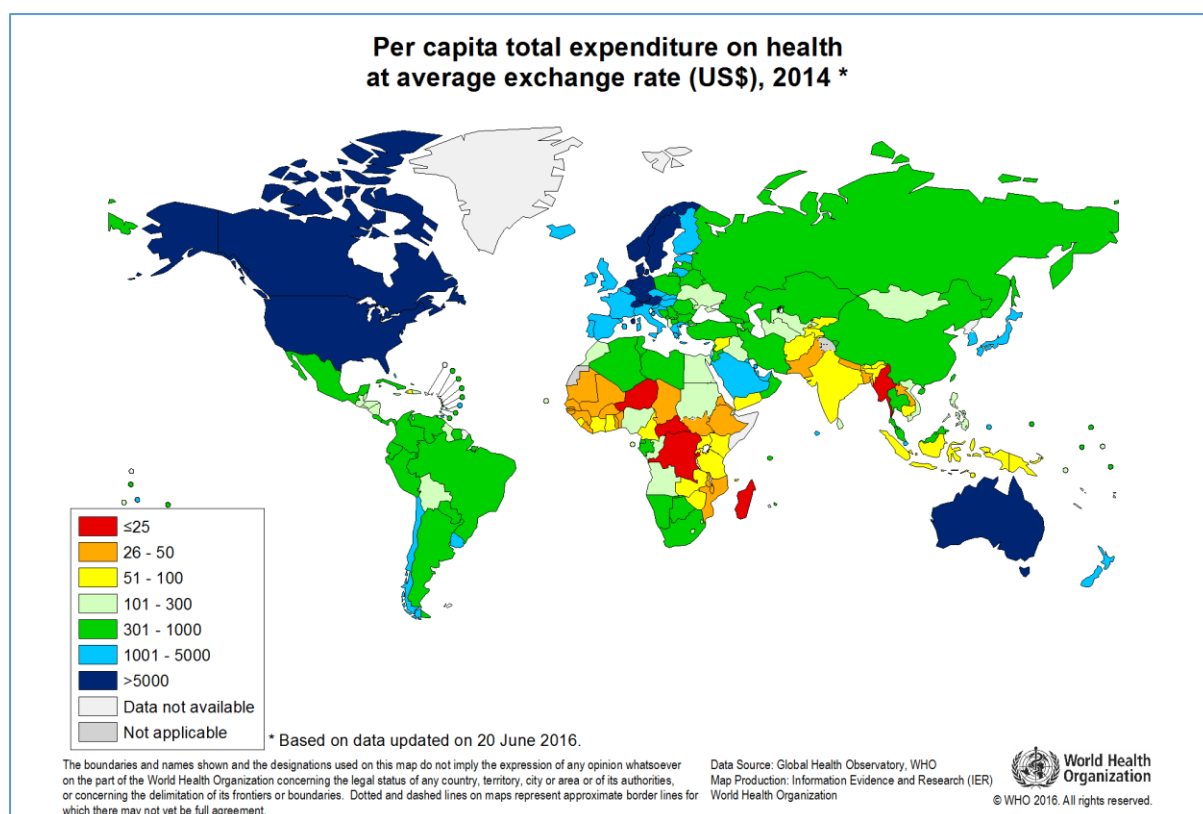


Figure 2 - per capita health expenditure 2014 (Source: WHO Global Health Observatory, 2016)

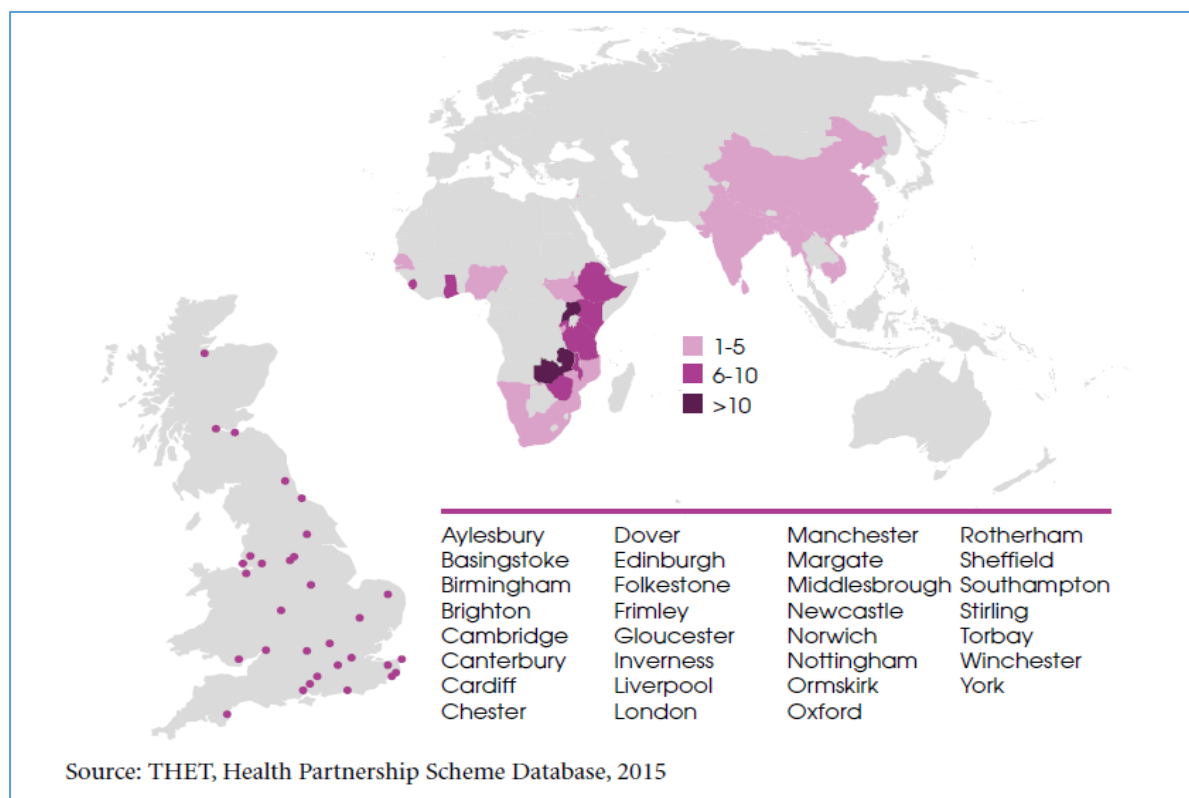


Figure 3 - THET HPS Partnerships by country (reprinted from APPG, 2015, 36)

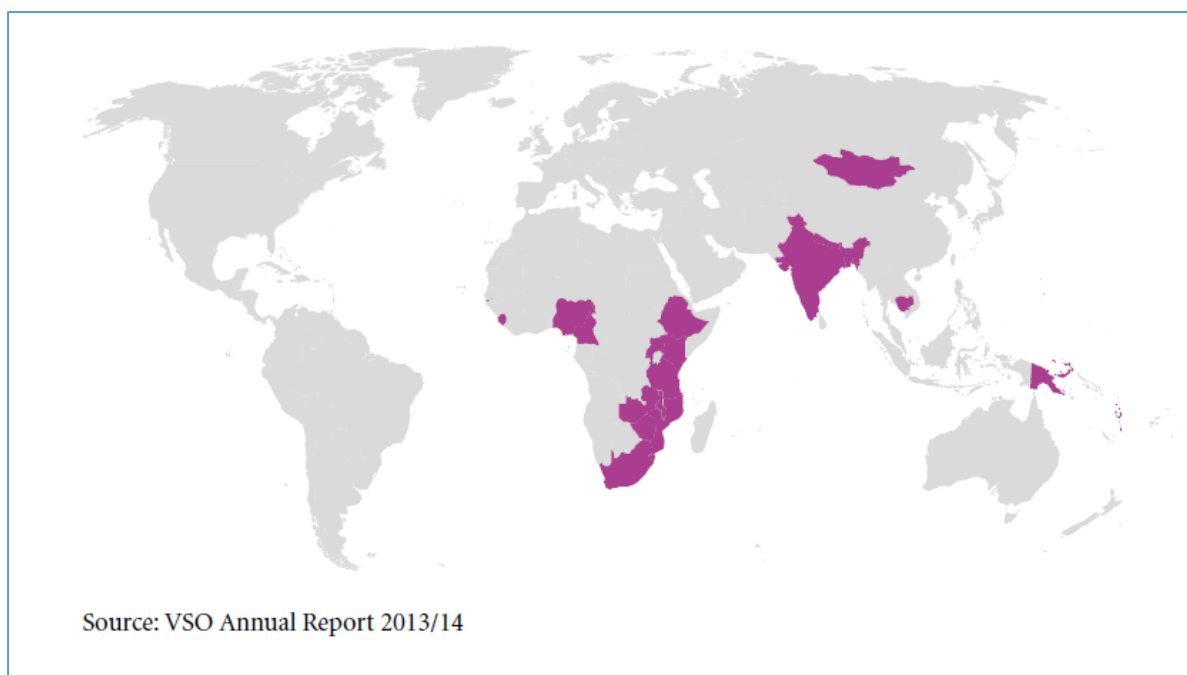


Figure 4 - VSO countries (reprinted from APPG, 2015, 37)

The African All-Parliamentary Group's report's note of caution that 'easy wins should not be prioritised over tasks that are more complex, long-term, or have a higher risk of failure in order to meet targets' (2012, 36) has direct relevance here. This is especially so as the geographical distribution of the complex measures that compose HSS or UHC "need" does not necessarily map neatly onto measures of poverty, inequality or human development. This leaves politics: HSS has become of strategic importance because the 'easy wins' from 'scaling up vertical interventions in major communicable diseases and child and maternal health have largely been exhausted' (House of Commons International Development Committee, 2014, 5). HSS has thus become a strategic means to 'maximise the impact of unprecedented recent investment in areas such as tackling neglected tropical diseases... tackling growing and persistent issues such as non-communicable diseases, ageing populations, mental health, conflict-affected regions and under-provision in rural areas and urban slums' (*Ibid*). Under this conceptualisation, the geographies of GHPs being used to effect HSS fit into a vision of development as newly 'focussed', 'practical' and 'transparent' in which 'every penny counts' (DFID, 2011b). This may be, as Taylor and Harper (2014, 218) argue, evidence of the 'new managerialism' in development, which favours 'micro-accountability' and 'transparency' over 'politically-driven aid' (Mosse, 2004). GHPs function as 'mobilizing metaphors' (Mosse, 2004, 663) into which are increasingly enfolded the policy logics of development such that, especially in the UK case, global health and development have become largely synonymous in their means and ends. This is fascinating, not least

as global health is far too rarely explored by development theorists and has remained almost entirely within the academic purview of those researching health. In contrast, this exploration of GHPs as a site where global health and development intersect has opened up new geopolitical realms (and their geographies) as sites of critical reflection.

## **Conclusion**

This paper has examined the UK's commitment to GHPs as a means to achieving its global health and development goals. GHPs have become increasingly strategic 'levers of change' as attention has focussed on the reasons why many single-disease vertical interventions have failed to deliver sustained results. Underpinning their patchy performance, many have argued, are fundamental gaps in the healthcare systems of many countries whose inadequate infrastructure, health workers, skills and healthcare coverage meaning that interventions are not only often ineffective, but in many cases also have unexpected and pejorative effects (Farmer et al., 2013). The current health workforce "crisis" is one that touches all countries, but is arguably a particular concern for the UK government given the NHS's continued reliance on overseas healthcare workers (Stead, 2016). With the SDGs now including a mandate to extend UHC globally, global health and development objectives have become even more entwined. This is clearly evident in the UK's current global health strategy as well as the projects and priorities of DFID, one of the world's most significant development funders. With opinions on how to best achieve HSS and work towards UHC divided and evidence of 'what works' scarce; partnerships have been hailed as an effective vehicle by which to achieve ODA goals, geopolitical aspirations and strengthen the NHS through the mutual learning and reverse innovation. This example has allowed this paper not only to open up recent critical engagements with global health to a new empirical field, but it has also used this exploration to reflect on the geopolitical underpinnings of these GHPs and their resultant geographies. It is notable that while GHPs have attracted attention from across a variety of disciplines; geographers been slow to appreciate the significance of either their geographies or geopolitics. Indeed, the geographies of the UK's GHPs represents a complex geopolitical vision that reflects the aspirations of development policy far more than it does the goal of attending to the global health needs of the world's poorest. This begs further scrutiny.

Until now, while the (albeit limited) geographical writing on global health has been attuned to the field's geopolitical contours, it has shied away from asking far more basic questions of *where* global health actually takes place. Such a question is pertinent because *where* things take place is as much a geopolitical question as *how* and *why* they do. The geographies of global health and, indeed, of GHPs

are strategic, but they also demand critical reflection on the geopolitical basis of locational decisions, the reasoning behind them and the ways in which global health and development are at once synergistic and deeply at odds. We know that global health is really not global at all. We also know that equity remains an aspiration that the SDGs may well struggle to deliver. Moreover and as Richard Horton has controversially argued, global health may well be ‘an instrument for a new era of scientific, programmatic, and policy imperialism. A discipline in which those who claim the right to study, speak, argue, publish, perform, and judge (and whom we now politely call partners) are part of an apparatus of power, self-interest, and control that denies justice and dignity to billions of people worldwide’ (2014, 1702). These are strong words that perhaps only a *Lancet* editor could write, but they do chime with how the restricted geographies of GHPs explored here reflect manifestations of ‘power, self-interest and control’. They also demonstrate the impossibilities inherent in expecting global health to live up to its ‘global’ title. The global is only ever going to be partial, but we need to think more about *where* that partiality is located and *why*. Doing so will better direct us to a dissection of the strategic nature of the geopolitics underpinning the UK’s global health investment, something about which critical scholars of global health have thus far asked far too few questions.

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